UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

NEW PATIENT PROFILE

DATE: _____

Addressograph

Please complete this form to help us plan your care. This information will only be used by your Health Care Team. If there is a question you do not understand or do not wish to answer please leave it blank.

Language spoken: ❑ English ❑ Other: _____

Translator required: ❑ Yes ❑ No

1. How did you arrive at the hospital today?
   ❑ Public Transit ❑ Own Car ❑ Taxi ❑ Ambulance ❑ Wheel Trans
   ❑ Other: _____
2. Will transportation be a problem on your next visit? ❑ Yes ❑ No
3. Who came with you today?
   ❑ Family Member ❑ Friend ❑ Other: _____
4. Would you like this person in the examination room with you?
   ❑ Yes ❑ No ❑ During discussion only.
5. Do you have any other health considerations?

	For how long?		For how long?
❑ Diabetes		❑ Arthritis	
❑ Heart disease		❑ Fatigue	
❑ High blood pressure		❑ Surgery	
❑ Stroke		❑ Use Oxygen	
❑ Bleeding		❑ Breathing problems	
❑ Having difficulty walking		❑ Use a Walker	

   ❑ Other: _____
   ❑ Drains ❑ Ports ❑ Tubes ❑ Lines
   ❑ Colostomy ❑ Urostomy ❑ Other: _____
   ❑ Other Health Problems (Please List): _____

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6. Please list **ALL** your Medications:

5. Please list any allergies to Medications:

No ALLERGIES ❑

Patient Name: _____ Date: _____ MRN: _____

8. Do you have a drug coverage plan? ❑ Yes ❑ No
   ❑ From your work ❑ Trillium ❑ Home care ❑ Social Assistance ❑ Not sure

9. Have you lost any weight? ❑ Yes ❑ No ❑ Time Frame
   Have you gained any weight? ❑ Yes ❑ No ❑ Time Frame
   Do you have: Nausea ❑ Yes ❑ No ❑ Time Frame
   Vomiting ❑ Yes ❑ No ❑ Time Frame
   Constipation ❑ Yes ❑ No ❑ Time Frame
   Diarrhea ❑ Yes ❑ No ❑ Time Frame
   Problems passing urine ❑ Yes ❑ No ❑ Time Frame

PAIN MANAGEMENT:

10. Do you have any pain or discomfort? ❑ Yes ❑ No ❑ Time Frame
    Please describe the pain in your own words: _____

11. Does your medication take your pain away? ❑ Yes ❑ No
    Explain: _____

12. Does anything else help your pain? ☐ Heat ☐ Massage ☐ Other:

13. Are you having trouble sleeping? ❑ Yes ❑ No

14. Dealing with physical health problems can affect patients and their families in different ways. Can we be of help to you in any of these areas?

Emotions (personal)	❑ Yes	❑ No
Social (family and Friends)	❑ Yes	❑ No
Sexual/ body image changes (personal)	❑ Yes	❑ No
Domestic (home situation)	❑ Yes	❑ No
Financial (work related)	❑ Yes	❑ No

Please discuss these with your nurse and if required, a referral to the appropriate health team member will be made.

THANK YOU FOR COMPLETING THIS FORM

Patient Name: _____ Date: _____ MRN: _____

THIS PAGE IS TO BE COMPLETED BY THE NURSE

Is the patient aware of the importance of having a Family Doctor? ❑ Yes ❑ No

High Problem Area(s) identified;

1. ❑ Activity/rest _____
2. ❑ Circulation _____
3. ❑ Respiration _____
4. ❑ Elimination _____
5. ❑ Nutrition _____
6. ❑ Pain _____
7. ❑ Neuro Status _____
8. ❑ Protective mechanisms _____
   (skin, Blood counts)
9. ❑ Teaching/Learning _____
10. ❑ Emotional response _____

Referral made to: _____

Written materials given

- ❑ Radiation booklet
- ❑ Chemotherapy booklet
- ❑ Surgery package
- ❑ Site Card
- ❑ Drug Card
- ❑ Site binder
- ❑ Contact sheet/ business card
- ❑ Other: _____

Comments: _____

_____

_____

Signature: _____ Date: _____